Complaint of Discrimination in Employment Under Federal Government Contracts

U.S. Department of Labor
Employment Standards Administration
Office of Federal Contract Compliance Programs

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Instructions: Before completing this form, please read all instructions, including the Privacy Act statement below. Use this form to file a complaint of discrimination in employment under any of the OFCCP programs. Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

Privacy Act Notice: The Privacy Act of 1974 requires that the Department of Labor provide the following statements to each individual from whom it requests information.

(1) The authority for collecting this information is Executive Order 11246, as amended; Section 503 of the Rehabilitation Act of 1973, as amended; and/or the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, 38 U.S.C. 4212. The submission of this information is voluntary.

(2) This information is used to process complaints under the above Order or Acts. The information is used to conduct investigations of alleged violations of the Order or Acts enforced by OFCCP.

(3) A copy of this complaint will be provided to the employer against whom it is filed. The information collected may be verified with persons who may have knowledge pertinent to the complaint, may be used in the course of settlement negotiations with the employer, and/or in the course of presenting evidence at a hearing, or may be disclosed to other agencies with jurisdiction over the complaint.

(4) The provision of this information is voluntary; however, failure to provide the information will restrict the action which the U.S. Department of Labor can take on your behalf.

Non-Retaliation: OFCCP regulations require an employer to take all necessary steps to assure that there is no retaliation against any person who files a complaint or assists in its investigation. This includes any intimidation, threat, coercion or discrimination. Please notify OFCCP immediately if any alleged attempt at retaliation is made.

Prompt Filing: All complaints must be filed within a specified number of days following the latest occurrence of the alleged discrimination. Executive Order 11246 - 180 days; Rehabilitation and Veterans Acts - 300 days. Exceptions must be approved by the Deputy Assistant Secretary.

Name: ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss	Name of company you allege discriminated against you
Street Address	Street Address
City State ZIP Code	City State ZIP Code
Telephone No.	Telephone No.
Mail this form to Dept. of Labor OFCCP Regional Office:	Give date(s) of the latest occurrence(s) of the alleged discriminatory act(s):

Step 1: Check the box next to the program you are filing under (i.e., Executive Order 11246, as amended; Section 503 of the Rehabilitation Act of 1973, as amended, or the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, 38 U.S.C. 4212.)

Step 2: Under the program, check what you believe to be the **basis** for the discrimination against you, such as race, sex or national origin. If you think that there was more than one basis, more than one basis may be checked. You may also check more than one race/ethnic category.

☐ **Executive Order 11246**, as amended. This Order covers persons alleging discrimination because of race, color, religion, sex or national origin. If this is checked, your complaint may also be considered under Title VII of the Civil Rights Act of 1964. I believe I was (or continue to be) discriminated against because of my:

Bases:
- ____ **Race**
- ____ **Color**
- ____ **Religion**
- ____ **Sex ( ) Female ( ) Male**
- ____ **National Origin**
- ____ **Other**

- ____ Hispanic or Latino
- ____ Not Hispanic or Latino

- ____ American Indian or Alaska Native
- ____ Asian
- ____ Black or African American
- ____ Native Hawaiian or Other Pacific Islander
- ____ White

☐ **Section 503 of the Rehabilitation Act of 1973,** as amended. This Act covers individuals with a disability, persons with a history of physical or mental disability, and persons regarded as disabled by the employer. If this is checked, your complaint also will be considered under the Americans with Disabilities Act.

Basis: ____ Disability Please check if you are a veteran. Yes ____ No ____

☐ **Vietnam Era Veterans' Readjustment Assistance Act of 1974,** as amended, 38 U.S.C. 4212. This Act covers special disabled veterar veterans of the Vietnam Era, and other protected veterans.

Bases: ____ Special Disabled Veteran ____ Other protected Veteran
____ Veteran of the Vietnam Era (Specify conflict _____)

IF YOUR COMPLAINT IS BASED ON VETERAN STATUS, CHECK THE FOLLOWING APPLICABLE BOX(ES):

☐ I am entitled to disability compensation under laws administered by the Department of Veterans Affairs for a disability rated at 30% or more; or rated at 10 or 20% and have been officially determined to have a serious employment disabilty. If you have checked this box, submit documentation from the Department of Veterans Affairs with this form.

☐ I was discharged or released from active duty for a service connected disability. If you have checked this box, submit medical information resulting in your discharge or release with this form. (This information is available from your Master Military Record at the National Personnel Record Center, 9700 Page Blvd., St. Louis, MO 63132.)

☐ I served on active duty for a period of more than 180 days, and was discharged or released with other than a dishonorable discharge, and the active duty occurred in the Republic of Vietnam between February 28, 1961, and May 7, 1975; or between August 5, 1964, and May 7, 1975 in all other cases.

☐ I served on active duty during a war or in a campaign or expedition for which a campaign badge has been authorized.

Step 3: Check those actions which you believe the employer took or failed to take **because of** your race, color, religion, sex, national origin, disability or veteran status (more than one may be checked):

Issue(s):

____ Hiring	____ Promotion	____ Job Assignment	____ Accommodation to Disability
____ Termination	____ Demotion	____ Training and Apprenticeship	____ Sabbath Day Observance
____ Layoff	____ Seniority	____ Segregated Facilities	____ Intimidation
____ Recall	____ Harassment	____ Retaliation	____ Other: _____
____ Wages	____ Job Benefits	____ Pregnancy Leave Policy	

FOR EACH ISSUE, EXPLAIN IN YOUR STATEMENT BELOW HOW YOU WERE DISCRIMINATED AGAINST.

1. Do you know any other employees or applicants of your group who were treated in the same way (checked above) you allege you were?

   ☐ Yes ☐ No If, yes, include their names in your statement below and explain how they were treated.

2. Do you know any other employees or applicants who are NOT of your group who were treated in the same way (checked above) you allege you were?

   ☐ Yes ☐ No If, yes, include their names in your statement below and explain how they were treated.

THE COMPLAINT

Describe in detail the alleged discriminatory act(s).

PLEASE INCLUDE:

- Why you believe the act(s) was because of your disability, veteran status, race, color, religion, sex or national origin;
- Dates, places, names and titles of persons involved and witnesses, if any;
- What harm, if any, was caused to you or others with whom you work as a result of the alleged discriminatory act(s);
- What explanation, if any, was offered for the act(s) by the employer;
- Any information you may have on federal contracts held by the employer.

If this is a complaint based on **disability,** describe the disability, your history of disability, or why you think the employer regarded you as disabled.

(Additional pages may be added to this form. Please put your name at the top of each page.)

If you have sought assistance in resolving this complaint from another source (another agency, a lawyer, internal grievance procedure, etc.) please indicate here and the name of the source, the date you sought assistance, and the result, if any:

FRIEND OR RELATIVE:

Please notify OFCCP if you change your address or phone number. You may indicate here a person who would know how to reach you if OFCCP is unable to reach you at your own address or phone.

Name _____ Street _____

Relationship _____ City/State _____

Telephone _____ ZIP Code _____

FILED ELSEWHERE?

If you have filed this complaint or a similar one elsewhere, please tell us:

Name _____

Address _____

_____

Person _____ Phone _____

ARE YOU REPRESENTED?

If you are represented by an attorney or other person or organization, please tell us:

Name _____

Address _____

_____

Person _____ Phone _____

SIGNATURE AND CERTIFICATION

I certify that the information given above is true and correct to the best of my knowledge or belief. (A willful false statement is punishable by law: 18 U.S.C. 1001.) I hereby authorize the release of any medical information needed for the investigation.

Signature of Complainant _____ Date _____

Public Burden Statement

We estimate that it will take an average of 1.28 hours to complete this complaint form, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information. If you have any comments regarding these estimates or any other aspect of this complaint form, including suggestions for reducing this burden, send them to the Office of Federal Contract Compliance Programs Policy Division (1215-0131) 200 Constitution Avenue, N.W., Room C3310, Washington, D.C. 20210.
DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Do not write below this line

The complainant has reaffirmed this complaint in my presence. This complaint is not now the basis of an investigation under Executive Order 11246, as amended; Section 503 of the Rehabilitation Act of 1973, as amended; and/or the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, 38 U.S.C. 4212.

Name of Investigator _____ Title _____ Signature of Investigator _____ Date _____